DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45d 3/09/14

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 815 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>AMENDED<br><br>During an annual recertification survey and complaint investigation (#32579) completed on January 23, 2014, at NHC HealthCare, Cookeville, deficiencies were cited in relation to the complaint. | F 000 | This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, review of facility investigation reports, observation, and interview, the facility failed to revise the care plan following | F 280 | (Begin Tag F280) It the policy of this facility that each resident participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed with 7 days after the completion of the comprehensive assessment. Some of the many ways that this has been achieved for resident #11 and #19 has been that since their admission each resident or their responsible party has had the opportunity to participate in their care plan. At each of these previous care plans all medications were reviewed and plans were developed as a result of the comprehensive assessment. | 2/13/14 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: JSTONE

TITLE: Jeremy Stoner, NHA - Administrator - 2/21/2014

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 815 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 280 | Continued From page 1<br>a resident incident for one resident (#11) and for current medication interventions for one resident (#19) of thirty residents reviewed.<br><br>The findings included:<br><br>Resident #11 was admitted to the facility on January 24, 2007, with diagnoses including Dementia, Bipolar Disorder with Psychotic Features, Anxiety State, Paranoia, Osteoporosis, Osteoarthritis, Hypertension, Chronic Cerebral Atrophy, Peptic Ulcer Disease, and B-12 Deficiency.<br><br>Medical record review of the Minimum Data Set (MDS) Significant Change dated September 23, 2013, revealed the resident required extensive assistance of two persons for transfers, bathing, dressing, grooming, and toileting; required extensive assistance of one person for eating; was always continent of bowel and frequently incontinent of bladder.<br><br>Review of the facility's investigation dated September 28, 2013, revealed at 7:25 p.m., the resident received a "cut" to the left lower leg during a transfer in the resident's room. Further review of the facility's investigation documentation revealed the Certified Nursing Assistant (CNA) was transferring the resident from the chair to the bed. Continued review of the facility's investigation documentation revealed the question, "...How much assistance does the patient require in transfer?..." with the response, "...2 person or mechanical lift..."<br><br>Medical record review of the Quarterly MDS dated December 23, 2013, revealed the resident required extensive assistance of two people for | F 280 | Under the supervision of the Director of Nurses it was determined that two resident were affected by this deficient practice and on January 23, 2014 resident #11's care plan was revised to one person and a lift or a 2+ person transfer. We also added padding the bars on the wheelchair and the removal of bedrail to the patient care plan. On January 23, 2014 resident #19's patient care plan was updated to remove Cymbalta from the care plan and interventions to address Seroquel and Lorazepam were included.<br><br>To enhance currently compliant operations and under the supervision of the Director of Nurses, on February 10, 2014 all patient care plans were reviewed by the patient care plan team (which consists of the following members MDS PCP Coordinator, Director of Social Services, Director of Dietary, Activity Department Head, ADON and/or the DON) , to ensure care plans were current and up to date. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 315 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 280 | Continued From page 2<br>bathing, dressing, grooming, transfers, and toileting; extensive assistance of one person for eating; was always incontinent of bowel and frequently incontinent of bladder.<br><br>Medical record review of the care plan dated October 3, 2013, and revised on December 31, 2013, revealed no documentation of the amount and type of assistance the resident required with transfers and Activities of Daily Living. Continued medical record review of the care plan revealed no documentation the front lower bars on the wheelchair were to be padded and wrapped with ace wraps. Further medical record review of the care plan revealed no documentation the side rails were removed from the bed and were not to be reapplied.<br><br>Observation of the resident on January 23, 2014, at 1:25 p.m., in the resident's room, revealed the resident was sitting in a rock-n-go chair with an alarm in place, support bars on the bilateral from wheelchair bars were wrapped with cotton batting and covered with wraps. Observation of the resident's bed revealed the bed rails had been removed from the bed.<br><br>Interview with CNA #1 on January 23, 2014, at 2:10 p.m., at the 400 hall nursing station, confirmed the resident required use of a stand-up lift or two people for transfers, the side rails were removed from the bed after the accident, and the wheelchair front bars were padded to prevent skin injuries.<br><br>Interview with the Director of Nursing (DON) on January 23, 2014, at 9:40 a.m., in the conference room, confirmed the care plan did not address the assistance required for transfers nor the fact | F 280 | We began in-services on January 23, 2014 and continued through each shift with each employee scheduled, until February 13, 2014. (The update and revision of the patient's plan of care are based upon assessment of patient, change in MD orders and patient preference. All licensed nurses and care plan team were in-serviced on updating and revising of patient care plans. The patient care plan team and all licensed nurses are responsible for updating the patient care plans. Revisions are communicated on the 24 hours observation sheet and shift to shift report.) All employees not scheduled were called. New employees receive the training as part of their new employee orientation. Our only contracted employees are therapist and they receive the appropriate training as part of the orientation to our building's operations. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 816 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 280 | Continued From page 3<br>the wheelchair bars were to remain padded. Resident #19 was readmitted to the facility on September 3, 2013, with diagnoses including possible Transischemic Attack (mini-stroke), Severe Pulmonary Hypertension, Congestive Heart Failure, History of Myocardial Infarction, and Depressive Disorder.<br><br>Review of the Clinical Pharmacy Review dated September 3, 2013, revealed the resident had been readmitted with physician's orders for Lorazepam (antianxiety) and Seroquel (antipsychotic).<br><br>Review of the Physicians Recapitulation Orders dated January 2014, revealed, the resident received Lorazepam and Seroquel daily.<br><br>Review of the Care Plan dated November 5, 2013, revealed care plan interventions for Cymbalta (antidepressant) and no interventions for Lorazepam or Seroquel.<br><br>Interview with the Assistant Director of Nursing on January 23, 2014, at 9:40 a.m., at the 100/200 hall nurse's station, confirmed the care plan had not been revised to reflect the resident's current medication regimen. | F 280 | A quality-assurance program was implemented under the direction of the Director of Nurses to monitor the proper completion of the patient care plans. The Director of Nurses or designated quality assurance representative will perform the following system changes: An audit will be conducted of all care plans to ensure physician orders and changes in care are updated on the care plans. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. The first reporting will occur at the March 2014 meeting of the Quality Assurance Committee which consists of the Medical Director, Director of Nursing, Director of HIM, Director of Dietary and Administrator. (End Tag F280) | |
| F 323 SS=G | COMPLAINT #32579<br>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives | F 323 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 815 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 4<br>adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, review of facility investigation, observation, and interview, the facility failed to ensure staff transferred a resident in a manner to prevent accidents for one resident (#11) of three residents reviewed for accidents. The facility's failure to transfer the resident according to the resident's assessment resulted in harm to resident #11.<br><br>The findings included:<br><br>Resident #11 was admitted to the facility on January 24, 2007, with diagnoses including Dementia, Bipolar Disorder with Psychotic Features, Anxiety State, Paranoia, Osteoporosis, Osteoarthritis, Hypertension, Chronic Cerebral Atrophy, Peptic Ulcer Disease, and B-12 Deficiency.<br><br>Medical record review of the ADL 31 Day Look-back dated August 30 through September 30, 2013, revealed the resident required one to two persons for transfers.<br><br>Medical record review of the Monthly Nursing Summary Report dated September 3, 2013, revealed, "...Current Modes of Transfer: Lifted manually Lifted mechanically..."<br><br>Medical record review of the Minimum Data Set (MDS) Significant Change dated September 23, | F 323 | (Begin Tag F323) It is the policy of this facility to insure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistant devices to prevent accidents. Some of the many ways that this has been achieved for resident #11 is by periodically reviewing medication with potential adverse effects associated with falls, providing motion sensor alarms and a low bed. In this case many changes have already been made to ensure that resident #11 would remain free of accidents and incidents. These changes include the removal of the bed rail and padding the bars on resident #11's wheelchair. | 2/13/14 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 815 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 5<br>2013, revealed the resident required extensive assistance of two persons for transfers.<br><br>Medical record review of the nurse's notes for September 2013, revealed, "9/4/13 1:55 p (p.m.) (up) dly (daily) in rock-n-go w/c (wheelchair), Requires ext (extensive) assist (assistance) (with) locomotion. Non-amb (non-ambulatory), 0 (no) walking occurred in room/corridor. Requires ext. assist (with) ADLs (Activities of Daily Living)...Requires ext assist (with) meals...9/18/13 @ (at) 6:48 p (p.m.)...Assist x 2 (two people) for transfers...9/25/13 11:15 A (up) dly in rock-n-go w.c. Requires ext assist (with) locomotion. Non-amb. Ext assist (with) ADL's...Requires ext assist (with) meals..."<br><br>Review of an Investigation of Incident dated September 28, 2013, revealed, at 7:25 p.m., the resident received a cut to the left lower leg during a transfer in the resident's room. Further review of the investigation revealed the Certified Nursing Assistant (CNA) was transferring the resident from the chair to the bed. Continued review of the investigation revealed the question, "...How much assistance does the patient require in transfer?..." with the response, "...2 person or mechanical lift..." Further review of the investigation revealed one CNA was transferring the resident.<br><br>Review of a statement written by CNA #3 dated September 28, 2013, revealed, "...When I transferred...(named resident #11) from...wheelchair to...bed...became combative with me while holding...When I laid...down I noticed blood on my gloves and arm. That is when I realized the skin tear on...left leg. It had gotten caught on the bottom of...bed rail..." | F 323 | Under the supervision of the Director of Nurses it was determined that all resident are at risk for accidents relating to transfers therefore on September 28, 2013 we reviewed all resident methods of transfer and the amount of assistance needed. We also conducted in-service training for transfers and mechanical lifts on October 1,2013. Additionally, on January 23, 2014 we reviewed all resident methods of transfer and the amount of assistance needed. On January 23, 2014 resident #11's care plan was revised to one person and a lift or a 2+ person transfer. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 815 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 6<br>Review of a statement written by CNA #4 dated September 28, 2013, revealed, "...When I was getting my resident ready for bed I heard my coworker, (named CNA #3), saying that...has blood on...gloves and arm. I came around the corner to see if I could help. That's when I noticed the skin tear on...left leg. I asked...how...did...get that skin tear...said it had gotten caught on the bottom part of the rail. After that we went and got the nurse..."<br><br>Review of the Emergency Department (ED) report dated September 28, 2013, revealed the resident presented to the ED by ambulance with complaints of leg injury. Continued review of the ED record revealed, "...EMS (Emergency Medical Services) state resident was being moved...skin became caught on a foreign object, and was subsequently torn. The resident presents with a laceration 8 cm (centimeters), clean, irregular L shaped tear on anterolateral leg...Positive for laceration, pain, of the lateral aspect of the left calf, 10 cm laceration in L shape on lateral leg..." Continued review of the ED record Physician Documentation revealed, "...noted in the lateral aspect of left calf: laceration 8 cm laceration in "L" pattern, L (left) anterolateral leg..." Further review of the ED record revealed, wound repair of "...8 cm full thickness laceration to lateral aspect of calf, irregularly shaped. Wound cleansed, irrigated, and explored. Subcutaneous tissue closed with 7 sutures and skin closed with 8 sutures..."<br><br>Review of a staff in-service Transfers and Mechanical Lifts dated October 1, 2013, revealed, "Every Resident under your care must be transferred as care planned no exceptions. If your resident is a two person transfer you must | F 323 | To enhance currently compliant operations and under the direction of the Director of Nurses, on February 13, 2014 we completed in-service training for transfers and mechanical lifts.<br>In-services began January 23, 2014 and continued through each shift with each employee scheduled, until February 13, 2014. All employees not scheduled were called. New employees receive the training as part of their new employee orientation. Our only contracted employees are therapist and they receive the appropriate training as part of the orientation to our building's operations. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 815 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 7<br>have two people to transfer this resident every time. All Manual Transfers require the use of a gait belt, no exceptions. If your resident requires the use of a lift for transfers you must use the appropriate lift to transfer this resident every time...Improper transferring of the resident can and does cause serious injury to our residents..."<br><br>Observation of the resident on January 23, 2014, at 8:30 a.m., in the resident's room, revealed the resident seated in a chair with the lower bars padded. Continued observation revealed the resident did not respond to questions.<br><br>Observation of the resident on January 23, 2014, at 11:10 a.m., revealed the CNA taking the resident to the bathroom, cleaning the resident, and taking the resident to lunch.<br><br>Interview with CNA #1 on January 24, 2013, at 1:30 p.m., at the 300/400 hall nursing station, revealed staff used a stand-up lift or two people to transfer the resident. Continued interview with CNA #1 revealed two people were usually present even if the lift was used.<br><br>Interview with CNA #2 on January 23, 2014, at 4:15 p.m., at the 300/400 hall nursing station, revealed the resident was transferred with two people or using a lift. Continued interview with CNA #2 revealed staff used the lift more often since the resident can become combative with transfers.<br><br>Interview with the Director of Nursing (DON) on January 23, 2014, at 9:40 a.m., in the conference room, revealed in-services were begun the day of the incident on September 26, 2013, for all staff regarding Transfers and Mechanical Lifts. | F 323 | Effective February 1 2014, a quality assurance program was implemented under the supervision of the Director of Nurses to monitor resident requiring staff assistance. The Director of Nurses or designated quality-assurance representative will perform the following systematic changes: random direct observation (Direct observation will occur per shift by licensed nurse supervisors as they make rounds and perform responsibilities, as well as these additional individuals DON, ADON, and Staff Educator. These observations will include all supervisors, all shifts, including weekends), interview and Patient Care Plan (Patient Care plans will be revised based upon assessment of patient, change in MD orders and patient preference) review of residents requiring assistance with transfer. We will specifically, include resident #11 in each study time frame. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. Our plans are to formally report to the QA Committee for the months of March, April and May. The QA Committee has authority to extend, modify or end any required QA reporting. The Quality Assurance Committee consists of the Medical Director, Director of Nursing, Director of HIM, Director of Dietary and Administrator. (End Tag F323) | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 815 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 8<br>Further interview confirmed when the resident sustained a laceration to the leg requiring sutures, only one CNA was transferring the resident to bed. | F 323 | (Begin Tag F371) It is the policy of this facility to 1. Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and 2. Store, prepare, distribute and serve food under sanitary conditions. Some of the many ways that this has been achieved for our residents is by ordering food from vendors who adhere to dietary guidelines outlined by the FDA. All food is stored in sanitary conditions, and is neatly organized. Food stored in our freezers are frozen solid and food stored in refrigerators are kept at temperatures at or below 41 degrees fahrenheit. Dry storage food is left in original containers until needed and our stock is regularly rotated. In addition we regularly monitor the sanitation levels of our dishwasher and three compartment sink.<br><br>Under the supervision of the Director of Dietary it was determined that all residents receive food prepared in our kitchen, on January 21, 2014 the Director of Dietary reviewed the proper method for handling clean and dirty dishwasher racks with all kitchen employees. The Director then observed all kitchen staff handle the clean and dirty racks according to the proper method. | |
| | c/o #32679 | | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility dietary department failed to prevent cross contamination while processing the dishes in the dish room.<br><br>The findings included:<br><br>Observation and interview with the morning cook on January 21, 2014, at 9:35 a.m., in the dietary department dish room, revealed the dish machine was in operation. Further observation revealed the dietary staff member operating the dish machine pushed a rack containing dirty dishes into the rack of clean dishes inside the dish machine in two consecutive operations of the dish | F 371 | | 2/13/14 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 816 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 371 | Continued From page 9<br>machine, thereby cross contaminating the cleaned dishes. Further interview with the cook confirmed the dietary staff member failed to properly process the dishes by having the dirty dishes come in contact with the clean dishes. | F 371 | To enhance the currently compliant operations and under the direction of the Director of Dietary, on January 21, 2014 all kitchen staff were in-serviced on the proper method of handling dirty and clean dishwasher racks. In-services began January 23, 2014 and continued through each shift with each employee scheduled, until February 13, 2014. All employees not scheduled were called. New employees receive the training as part of their new employee orientation. Our only contracted employees are therapist and they do not operate the dish machine, therefore dish machine operation is not included in their orientation..<br><br>Effective, February 1, 2014 a quality-assurance program was implemented under the supervision of the Director of Dietary to monitor dish-machine use and proper rack handling. The Director of Dietary or designated quality-assurance representative will perform the following systematic changes: weekly direct monitoring of the dish-machine operation. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. The Quality Assurance Committee consists of the Medical Director, Director of Nursing, Director of HIM, Director of Dietary and Administrator. (End Tag F371) | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can | F 431 | | 2/13/14 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 815 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 431 | Continued From page 10<br>be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure expired items were discarded and food items were correctly labeled in two of two medication rooms observed.<br><br>The findings included:<br><br>Observation of the medication room for the 100/200 hall on January 23, 2014, at 1:50 p.m., revealed a 1000 ml (milliliter) container of Glucerna 1.5 calories (used for tube feedings) sitting on the shelf next to other containers of tube feeding. Continued observation revealed the container had 600 ml remaining in it but there was no resident name on it nor was there a date when the container was opened.<br><br>Interview with LPN (Licensed Practical Nurse) #1 on January 23, 2014, at 2:00 p.m., in the medication room, confirmed the container of tube feeding was undated, unlabeled, and available for resident use.<br><br>Observation of the medication room for the 300/400 hall on January 23, 2014, at 2:15 p.m., revealed a partial bottle of wine in the refrigerator used for resident nutrition. Continued observation of the refrigerator revealed there was no name on the bottle nor was there a date when it was opened.<br><br>Interview with LPN #2 on January 23, 2014, at 2:40 p.m., in the medication room, confirmed the | F 431 | (Begin Tag F431) It is the policy of this facility that drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Some of the many ways that this has been achieved is by the periodic review of our consultant pharmacist. During the consultant pharmacy review medication and biological labeling are reviewed and audited.<br><br>Under the supervision of the Director of Nurses it was determined that only one patient had an order for Glucerna and only one patient had an order for wine, then only two residents were affected by the cited deficiency. On January 23 2014 the Glucerna and wine were disposed. The wine was replaced and labeled on January 24 2014. The need to label drugs and biologicals was reviewed with the nurses. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 515 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 431 | Continued From page 11<br>wine bottle belonged to one of the residents but it was not labeled with the resident's name or the date of opening. | F 431 | To enhance currently compliant operations and under the direction of the Director of Nurses. In-services began January 23, 2014 and continued through each shift with each employee scheduled, until February 13, 2014. All employees not scheduled were called. New employees receive the training as part of their new employee orientation. Our only contracted employees are therapist and they receive the appropriate training as part of the orientation to our building's operations.<br><br>Effective, February 1 2014, a quality assurance program was implemented under the supervision of the director of nurses to monitor the usage and labeling of biologicals. The director of nurses or designated quality-assurance representative will perform the following systemic changes: randomly check each nurses station daily. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. The Quality Assurance Committee consists of the Medical Director, Director of Nursing, Director of HIM, Director of Dietary and Administrator. (End Tag F431) | 2/24/14 |
| F 494 SS=C | 483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY<br><br>A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b).<br><br>A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section.<br><br>Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the CFR Title 42, Volumn 3, PART 483 Requirements for States and Long Term Care Facilities (Nurse Aide Training Programs) and interview, the facility failed to | F 494 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 515 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 494 | Continued From page 12<br>ensure no nurse aide was charged for any portion of the program.<br><br>The findings included:<br><br>Review of the Requirements for States and Long Term Care (LTC) Nurse Aide Training Requirements revealed, "...Sec.483.152(c) Prohibition of charges. (1) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program may be charged for any portion of the program..."<br><br>Interviews with three Nurse Aide Trainees (NAT) currently enrolled in the NAT class provided by the facility on January 23, 2014, from 10:05 a.m., to 10:10 a.m., in the conference room, revealed each trainee had been required to pay $225.00 for class materials and training.<br><br>Interview with the Staff Education Coordinator on January 23, 2014, at 10:10 a.m., in the Staff Education Coordinator's office, confirmed the NAT students were not employed during the training, and the charge for the class was $225.00 for the training and materials. Continued interview confirmed the Staff Education Coordinator had no knowledge of persons who had been hired by the facility after completing the class being reimbursed for the cost of the class.<br><br>Interview with NAT #1 on January 23, 2014, at 10:40 a.m., in the conference room, confirmed the nurse aide had been enrolled in the class that started October 7, 2013, and was hired by the facility on October 30, 2013. Continued interview confirmed NAT #1 had not been reimbursed by | F 494 | (Begin Tag F494) It is the policy of this facility to comply with all regulatory requirements governing the nurse aide training program. Some of the many ways this has been achieved has been the in successful training of certified nurse aids.<br><br>No residents were affected by the cited deficiency.<br><br>We no longer charge for the certified nurse aide class and a list was compiled of students currently employed and completing the CNA class. We identified 13 students and those students will be reimbursed for the class on February 24, 2014.<br><br>Effective, February 1, 2014 a quality assurance program was implemented under the supervision of the Administrator to monitor fees charged for the class. The Administrator or designated quality-assurance representative will perform the following systematic changes: each month a review of fees charge will be reviewed. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. The Quality Assurance Committee consists of the Medical Director, Director of Nursing, Director of HIM, Director of Dietary and Administrator. (End Tag F494) | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 815 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 494 | Continued From page 13<br>the facility for the NAT class.<br><br>Interview with the Administrator in the Administrator's office on January 23, 2014, at 10:45 a.m., confirmed the facility had not reimbursed nurse aides for the cost of the class after the nurse aides completed the class and were employed by the facility. | F 494 | (Begin Tag F514) It is the policy of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. Some of the many ways that this has been achieved is the creation and maintenance of numerous medical records, that available for review and systemically organized. Numerous internal and external record reviews by consultants and payors have demonstrated that our records are accurately documented.<br><br>Under the supervision of the Health Information Department Head it was determined that only one resident was affected by the cited deficiency, on January 21, 2014 the physician of resident #78 was notified and we obtained current orders. We conducted a full center audit of all residents and found no other charts were missing signed orders.<br><br>To enhance currently compliant operations and under the direction of the health information department head, on January 24, 2014 a tracking sheet was revised and will be used to determine when orders are due and when complete. | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and interview, the facility failed to maintain a complete medical record for one resident (#78) of thirty residents reviewed.<br><br>The findings included:<br><br>Resident #78 was admitted to the facility on June 1, 2011, with diagnoses including Alzheimer's Disease, Vascular Dementia with Depressed | F 514 | | 2/5/14 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445110 | A. BUILDING _____ B. WING _____ | 01/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, COOKEVILLE | 615 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 514 | Continued From page 14<br>Mood, Muscular Wasting, Aftercare Left Ankle Fracture, and History of Depression.<br><br>Review of the medical record revealed the last monthly recapitulation orders signed by the physician were dated October 2 and 3, 2013.<br><br>Interview with the Assistant Director of Nursing on January 21, 2014, at 2:10 p.m., at the 300/400 hall nursing station, confirmed the record for resident #78 did not contain current monthly recapitulation orders signed by the physician.<br><br>Interview with the Director of Nursing, on January 21, 2014, at 2:50 p.m., in the conference room, confirmed the facility failed to have current physician orders in the record for resident #78, and the signed orders were to be completed in December 2013. | F 514 | Effective, February 5, 2014 a quality-assurance program was implemented under the supervision of the health information department head or designated quality-assurance representative will perform the following systematic changes: a 100% audit of all charts will be conducted. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. The Quality Assurance Committee consists of the Medical Director, Director of Nursing, Director of HIM, Director of Dietary and Administrator. (End Tag F514) | |